Indiana State Department of Health

LTC & ICF/MR HOMES

LTC Newsletter

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New Deputy State Health Commissioner

Sue Uhl, JD, joined the staff of the Indiana State Department of Health as Deputy State Health Commissioner on February 14, 2005.

Prior to joining the Indiana State Department of Health, Uhl was the assistant vice president and associate general counsel for Golden Rule Insurance Company in Indianapolis from 2001 to 2005. She was corporate counsel for the company from 1997 to 2001.

Her professional experience also includes 16 years with the Health and Hospital Corporation of Marion County in Indianapolis in various positions, including environmental health specialist and senior attorney.

Uhl received her bachelor's degree in natural resources and environmental sciences in 1979 from Purdue University. She earned a law degree from Indiana University, Indianapolis in 1987.

Uhl is currently serving on the Long-Term Care Committee of the American Council of Life Insurers and on the board of directors of the Big Brothers Big Sisters organization.

She also served on the Big Sisters board of directors from1999 to 2001, on the Arthur A. Jordan Branch of the YMCA board of managers from 1997 to 2000, and on the board of advisors for the West Central Solid Waste District from 1995 to 1998.

Uhl resides in Lizton, Ind. with her husband Mark Harrison, and is a native of Louisville, Kentucky. As a child she moved to Indianapolis, and is a graduate of North Central High School. ▪

Reprinted with permission from the February 16, 2005 issue of the ISDH Express

New Staff Member Joins Indiana Team at CMS

Heather Lang became the Indiana Principal Program Representative on January 10, 2005, replacing Ellen Greif, who will now serve as the Illinois Principal Program Representative.

Ms. Lang began her career with CMS (formerly the Health Care Financing Administration, HCFA) in 1998, when she joined the CMS Regional Office in Seattle, Washington. During her time in Region X, she served as a certification specialist for first Oregon and then Washington State, both long term care and non long term care. Ms. Lang also served as the Region X Regional Training Administrator (RTA) for four years. In June 2003, she transferred to CMS Region V, where she worked in outreach and training as part of the Survey and Certification Coordination Branch.

Prior to joining CMS, Ms. Lang worked as a laboratory technician in the field of molecular biology. She holds a Bachelor of Arts degree from Illinois Wesleyan University (Bloomington, Illinois) and will earn a Master of Science in Public Service Management from DePaul University (Chicago, Illinois) in the Fall of 2005. ▪

Inside This Issue

Inserts This Issue

Addendums

When the Division of Long Term Care ("Division") requests an addendum to a plan of correction (POC) the facility has submitted, the Division is requesting additional information in order to make a determination that the POC is acceptable. A request for an addendum does not negate the facility's original correction completion date. Therefore, it is not necessary to submit a correction completion date on the addendum unless the Division requests a different correction completion date.

An addendum may be submitted in letter format, or may be added to the text of the original POC. If the addendum is added to the text of the original POC, please indicate in some manner the portion that is the addendum.

Addendums may be submitted via regular mail, overnight delivery, or facsimile to 317/233-7322. For more information, contact the Supervisor of the Survey Area to which your facility is assigned. ▪

POC Pointers…

- ⇨ **Ensure that you have included a POC correction completion date**
- ⇨ **A POC correction completion date cannot be earlier than the survey exit date**
- ⇨ **The latest completion date on an acceptable POC will be considered the date the facility has alleged compliance**
- ⇨ **Ensure that resident names are not included in your POC**

QMA Certification and Annual In-Service Education

Effective January 1, 2005, the Qualified Medication Aide (QMA) certification process and in-service education requirement is mandatory every year. This is in accordance with Indiana Administrative Code 410 IAC 2-1-10. Under this rule all QMAs must meet the following three (3) requirements:

- Be certified by the Indiana State Department of Health (ISDH) every year;
- Obtain a minimum of six (6) hours per year of in-service education in the area of medication administration, beginning the year after initial certification; and
- Submit appropriate fee to the ISDH with recertification request.

All QMA certifications will expire on March 31 of each year. Annual in-service education of six (6) hours will need to be submitted to the ISDH for recertification. This in-service education will be obtained from March 1 through the last day of February of each year (example: expiration date of 03/31/2006, in-service education will be obtained from 03/01/2005 through 02/28/2006). In-service education should be recorded on the Qualified Medication Aide Record of Annual In-service Training form. A fee of $10.00 must also be submitted to the ISDH. Fees and in-service education training are due 30 days prior to the certificate expiration date (on or before March 1). The QMA Record of Annual In-service Training form and annual fee ($10.00) should be submitted together.

Annual in-service education must be in the area of medication administration. If the facility policy allows the QMA to perform the following: medication administration via a G-tube/J-tube, hemoccult testing, finger stick blood glucose testing, the annual in-service education must include those procedures.

Qualified Medication Aide Record of Annual In-service Training form and fees should be submitted to the ISDH. The form and fee should be sent to the Indiana from the QMA registry. Removal from the QMA registry will require completion of a QMA course and passing of the QMA competency test for reinstatement.

The Qualified Medication Aide Record of Annual In-service Training is attached and can be duplicated. Contact Nancy Adams 317/233-7480 or Nancy Gilbert at 317/233-7616 with additional questions. ▪

Resource Websites

Infection: Don't Pass It On!
Hand and Respiratory Hygiene info:
http://www.publichealth.va.gov/infectiondontpassiton/

Retail Food Establishment Sanitation Requirements
410 IAC 7-24 ***(New)***
http://www.in.gov/isdh/regsvcs/foodprot/pdf/410_iac_7-24.pdf

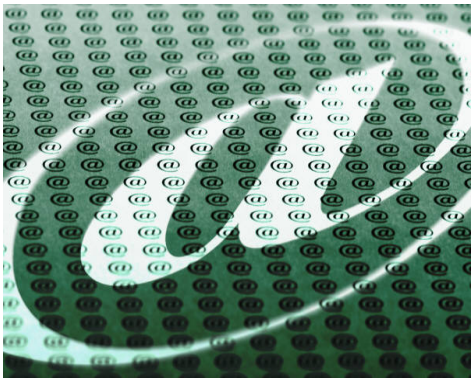
State Operations Manual Appendix P (Survey Protocols for LTC) & Appendix PP (Interpretive Guidelines for LTC Regulations)
(Revised F309 & F314)
http://www.cms.hhs.gov/manuals/107_som/som107_appendixtoc.asp

State Licensure Rules
410 IAC16.2 ***(New Sections Added)***
http://www.state.in.us/legislative/iac/T04100/A00162.PDF

Centers for Medicare and Medicaid Services
http://www.cms.hhs.gov/

Indiana State Department of Health (ISDH)
http://www.in.gov/isdh/

ISDH/Indiana Health Care Providers
http://www.in.gov/isdh/regsvcs/providers/



Emergency Fire Watch Procedures

Recently, Indiana experienced an ice storm that caused interruption of electrical power to at least 18 facilities over a widespread area. Luckily, through hard work and cooperation, the affected counties pulled thru this ordeal in good shape. One issue that arose during this event was the question of what is expected of facilities during a fire watch when the alarm system or sprinkler system is not functioning.

The Indiana State Department of Health, Division of Long Term Care ("Division") should be notified whenever a facility institutes a fire watch procedure, as such an event would constitute an unusual occurrence. The individual performing the fire watch rounds could be any staff member which the administrator designates. While performing this duty, this staff member may only be assigned to the fire watch—no other duties may be performed. The individual performing the fire watch must make rounds at 15 minute intervals. All areas of the building must be checked during these rounds. A written record of these rounds must be completed during each shift. These must be retained with the facilities Life Safety Code documentation.

The State Fire Marshal and some local fire departments require that facilities utilize only trained firefighters for this responsibility. In such circumstances, the facility may be required to recruit and pay an off-duty firefighter.

With the adoption of the 2000 Edition of The NFPA 101 Life Safety Code, it is now required that a fire watch be instituted:

K-154 Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1.

Although fire alarm systems are not mentioned in this rule, as the authority having jurisdiction, it is the Division's interpretation that this also applies to that system. Facilities should also address the possibility of implementing a fire watch, and should address procedures for such in the facility's fire plan. Please direct questions regarding this matter to Rick Powers, Life Safety Code Supervisor, 317-233-7471. ▪

What is "Culture Change"?

The current culture in most nursing homes revolves around the tasks to be performed to satisfy survey requirements. Changing the culture means changing the focus to the individuals, rather than the tasks, and looking at care practices, workplace practices, and the care environment. "Culture Change" is the current term for work over decades to humanize nursing homes. When focusing on individuals—person-centered care—the goal is for a "normal life" rather than one centered around institutional routines.

Nursing homes adopted a "medical model" of care long before most of us were involved in nursing homes. This model made nursing homes become "long-term care" hospitals. The result: individuals living in these "mini-hospitals" have been shown to experience feelings of hopelessness, homelessness, boredom, and "psychic despair." Are those the feelings we want our loved ones to experience?

Person-centered care allows staff to develop strong bonds and lasting relationships with their residents so they know, and are more able to meet, the individual's needs and wants. Some of the positive outcomes in homes where they have transformed their culture: higher satisfaction on resident and family surveys, higher satisfaction on staff surveys, fewer complaints, reduced use of anti-anxiety and antipsychotic medications, lower usage of supplements, fewer pressure ulcers, fewer restraints, less incontinence, higher census, and lower staff turnover.

Couldn't we all use that? ▪

Reprinted with permission from the Winter 2005 Health Care Excel newsletter, "Quality Counts".

Top 10 ICF-MR Deficiencies

Based on deficiencies cited January through December 2004

1. W249 Program Implementation
2. W149 Staff Treatment of Clients
3. W104 Governing Body
4. W227 Individual Program Plan
5. W154 Staff Treatment of Clients
6. W440 Evacuation Drills
7. W153 Staff Treatment of Clients
8. W198 Admissions, Transfers, Discharge
9. W369 Drug Administration
10. W125 Protection of Clients Rights

Bed Changes

It can be difficult to decipher when bed changes can be made, and what requirements must be followed when requesting them. Here are a few facts that can help:

- ***Certified*** bed changes (T18 SNF and/or T19 NF) can be made ***up to two times per cost reporting year*** (CRY)—***once on the first day of the CRY***—and ***once more on the first day of a subsequent quarter*** within that CRY. ***NOTE:*** Only one decrease per CRY is allowed.
- Requests must be submitted ***no later than*** 45 days prior to the effective date for the bed change.
- Call or e-mail ***well in advance*** to inquire if architectural plan review and/or fire safety inspections will be required for the requested bed change.
- Increasing the number of licensed beds requires a $10 per bed fee for the increase.

For more information, contact Jena Mendoza, Program Director-Provider Services, at 317/233-7794, or by e-mail at jmendoza@isdh.state.in.us. ▪

INSULIN STERILITY & STABILITY

Insulin manufacturers Eli Lilly and Novo Nordisk now recommend that **opened** insulin vials be used no longer than 28-30 days. The American Diabetic Association also recognizes that a loss of potency occurs in opened insulin vials after 30 days. Prior to this recommendation, the manufacturers advised to discard insulin vials after 200 punctures. Based on an average of 2 punctures per day for most patients, that would translate to about 90 days. ▪

Reporting Incidents

Did you know that you can report incidents online? Simply visit the following web page and click on the link!

http://www.in.gov/isdh/regsvcs/providers/contact.htm

Look for training on new Dining Assistants Program to be announced this Spring!

Top 10 LTC Deficiencies

Based on deficiencies cited January through December 2004

1. F324 Quality of Care
2. F281 Resident Assessment
3. F309 Quality of Care
4. F157 Notification of Rights and Services
5. F314 Quality of Care
6. F371 Dietary Services
7. F514 Administration
8. F441 Infection Control
9. F323 Quality of Care
10. F253 Environment

ALERT! ALERT! ALERT!

Effective November 12, 2004, Appendix PP, Tag F314, current Guidance to Surveyors, was revised. To complement the revision of F314, new language was added to Tag F309 to include definitions of non-pressure related ulcers. Please take time to review the F309 & F314 interpretive guideline changes to the Centers for Medicare and Medicaid Services' State Operations Manual at the following link:

http://www.cms.hhs.gov/manuals/107_som/som107ap_pp_guidelines_ltcf.pdf

Check out the changes to the Revised Food Code at the following web site:

http://www.in.gov/isdh/regsvcs/foodprot/food_laws.htm

Among the changes are...

- ✔ The hot holding requirement for potentially hazardous foods is reduced to 135 F.
- ✔ Hot water, when required, is defined as at least 100 F.

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Editor

Indiana State Department of Health

Indiana
Work in Progress

"The Indiana State Department of Health serves to promote, protect, and provide for the public health of people in Indiana."

Jobs in public service offer many rewards and challenges. If you are interested in a public service career, the Indiana State Department of Health (ISDH) offers a pleasant work environment and the opportunity for personal growth.

The ISDH currently has employment opportunities for nurses, laboratory, and information technology staff as well as a variety of other dedicated professionals.

The ISDH offers a flexible work schedule, a 37.5 hour work week, excellent benefits, and generous paid leave. We rarely require overtime, weekends, or holiday work.

Find out what opportunities await you by checking http://www.in.gov/isdh/about/hr or http://www.in.gov/jobs/stateemployment/jobbank.html

Equal Opportunity Employer

Indiana State Department of Health

Insert 1

Division of Long Term Care Telephone
Directory By Subject

Indiana State Department Of Health
Division of Long Term Care

TELEPHONE GUIDE

Arranged alphabetically by subject

All are Area Code 317

SUBJECT	CONTACT PERSON	EXTENSION
Administrator/DON, Facility Name/Address Changes	Jena Mendoza	233-7794
Bed Change Requests (Changing/Adding Licensed Bed/Classifications)	Jena Mendoza	233-7794
CNA Registry	Automated	233-7612
CNA Investigations	Zetra Allen	233-7772
CNA/QMA Training	Nancy Adams	233-7480
Director, Division of Long Term Care	Suzanne Hornstein	233-7289
Enforcement & Remedies	Stephen Upchurch	233-7613
Facility Data Inquiries	Sarah Roe	233-7904
FAX, Administration		233-7322
Incidents/Unusual Occurrences	Fax Voicemail Other	233-7494 233-5359 233-7442
Informal Dispute Resolution	Susie Scott	233-7651
License/Ownership Verification Information	Jena Mendoza	233-7794
License Renewal	Jena Mendoza	233-7794
Licensed Facility Files (Review/Copies)	Darlene Jones	233-7351
Licensure & Certification Applications/Procedures (for New Facilities and Changes of Ownership)	Jena Mendoza	233-7794
Life Safety Code	Rick Powers	233-7471
MDS/RAI Clinical Help Desk	Kimberly Honeycutt	233-4719
MDS Technical Help Desk	Technical Help Desk Staff	233-7206
Monitor Program	Debbie Beers	233-7067
Plans of Correction (POC), POC Extensions & Addenda	Area Supervisors	See Below
Plans & Specifications Approval (New Construction & Remodeling)	Dennis Ehlers	233-7588
Reporting	Tom Reed	233-7541
Rules & Regulations Questions	Debbie Beers	233-7067
Survey Manager	Kim Rhoades	233-7497
Transfer/Discharge of Residents	Jena Mendoza	233-7479
Unlicensed Homes/Facilities	Jody Anderson	233-7611
Waivers (Rule/Room Size Variance/ Nursing Services Variance)	Jena Mendoza	233-7794
Web Site Information	Sarah Roe	233-7904

AREA SUPERVISORS

Area 1	Judi Navarro	233-7617
Area 2	Brenda Buroker	233-7080
Area 3	Vacant	---
Area 4	Zetra Allen	233-7772
Area 5	Karen Powers	233-7753
Area 6	Pat Nicolaou	233-7441
Life Safety Code	Rick Powers	233-7471
ICF/MR North	Brenda Meredith	233-7894
ICF/MR South	Steve Corya	233-7561

Updated 3/2005

Insert 2

SF 51654, Qualified Medication Aide
Record of Annual Inservice Training

QUALIFIED MEDICATION AIDE RECORD OF ANNUAL INSERVICE TRAINING

State Form 51654 (3-04)
Indiana State Department of Health - Division of Long Term Care

QMA Name: _____ Certification #:_____
(please print full name)

Home Address: _____
(please print) street address (include Post Office box number, if applicable) City State Zip Code

Instructions: It is the QMA's responsibility to track hours of medication administration in-service training and supply proof of completion of in-service training to ISDH in conjunction with application for re-certification to be submitted annually in January. Annual in-service education shall include, but is not limited to medication administration via G-tube/J-Tube, hemoccult testing and finger stick blood glucose testing.

Date of Training	Title/Topic of Training	Location	Length of Training	Signature of Instructor

I submit the above information as proof of having met the six (6) hour per year in-service requirement and hereby apply for re-certification.

_____ _____
QMA Signature Date Submitted

Insert 3

ISDH/Nursing Home Associations
Roundtable Meeting
4th Quarter, 2004
Questions & Answers

(02/10/05)

ISDH/Nursing Home Associations Roundtable Meeting
4th Quarter, 2004
Questions

1. <u>ISDH Quality Assurance Process</u>

You have described in general the internal QA process related to surveys. However, we have some additional questions:

1. Are citings monitored between regions, survey teams and individual surveyors?
2. Is the monitoring process designed to flag variances among teams and individual surveyors? (E.g. One region cites things other regions do not.)
3. Is the monitoring process designed to identify subjectiveness among teams and individual surveyors?
4. What is the level of review conducted by the supervisors of individual surveyors citings?
5. Do the supervisors have the ability to override the field surveyors' decisions?

Answer: Long Term Care Division has an internal quality review and quality assurance process to monitor the quality of the survey process.

2. Communication with Facilities

The recent requests for information from facilities related to Flu Vaccine needs pointed out that the ISDH does not have an effective way to communicate quickly with facilities.

Does the department see this as an issue?
What steps do you anticipate ISDH might take to overcome this problem?

Answer: Yes – ISDH is looking at various options to assist with this issue.

3. Med Pass in Dining Room

A Complaint Surveyor in Area 6 was at a facility and made the comment that she was concerned that nursing staff was passing medications in the dining room during the meal. While this was not part of the complaint being surveyed, she still voiced concern that the licensed staff was doing so.

This has been an area of discussion since the release of the investigative protocol for dining and food service (7/1/99). Please note that on page 49 of the Survey Procedures for Long Term Care Facilities it is stated, "6. Observe for institutional medication pass practices that interfere with the quality of the resident's dining experience. This does not prohibit the administration of medications during the meal service for medications that are necessary to be given at a meal, nor does this prohibit a medication to be given during a meal upon request of a resident who is accustomed to taking the medication via the meal, as long as it has been determined that this practice does not interfere with the effectiveness of the medication."

Per review of a later document entitled Long Term Care Survey Protocol Questions and Answers available on the CMS (then HCFA) website a few years ago, this issue is addressed under area Task 5E Medication Pass and states that, "the procedures instruct the surveyor to observe for institutional medication pass practices that interfere with the quality of the residents' dining experience. This does NOT prohibit the administration of medications during meal service."

The response continues to state that a concern would be, "lining up residents in an institutional line

to get their medicines while their already served meals become cool (or improperly warm)." This was not the case in the scenario observed by the surveyor.

In the past, it has been understood that as long as there is sufficient staff to meet the needs of the residents requiring assistance with meal consumption, and as long as the residents are not troubled by the passing of medications at mealtime, this is not a concern. Many of the elderly have been accustomed to taking their medications with meals in the past, and it was understood that this would not be a concern unless there is a concern with sufficient staffing to assist with meal service.

Based upon the Surveyor's voiced concern to the DON, one would question if there has been a change in the opinion of ISDH in regard to this practice? I have not read any further guidance or clarification since this document posted on the website that would prohibit medication pass to be conducted in concert with meal service, as long as sufficient staff is available to assist with meal service. Please advise.

Answer: The federal investigative protocol for dining and food service directs surveyors to observe for institutional medication pass practices that interfere with the quality of the residents' dining experience. This does not prohibit the administration of medications during the meal service for medications that are necessary to be given at a meal, not does this prohibit a medication to be given during a meal upon the request of a resident who is accustomed to taking the medication with the meal, as long as it has been determined that this practice does not interfere with the effectiveness of the medication.

4. <u>Social Service Consultation reports</u>

Certain surveyors (mainly southern Indiana) continue to ask the facility administrators to provide them with a copy of the social service consultation reports. According to the ISDH staff some time ago, surveyors should not be asking for these reports; however, they can ask to verify the consultation hours if the SS consultation is required per regulations. Could you clarify? The consultation reports are confidential documents.

Answer: Surveyors will ask for evidence that the social service designee is receiving an average of 4 hours of consultation per month.

5. <u>Screening for signs/symptom of depression</u>

Survey teams in northern Indiana continue to cite facilities for not providing a means to verify that a screening for signs and symptoms of depression is being done routinely. Could ISDH reference a regulatory requirement for this standard OR clarify the issue?

Answer: The MDS requires periodic screening for depression; this is addressed in Section E1. Regulatory references are F272, F319, and F320.

6. <u>Standardized behavior management program</u>

Where is the requirement for facilities to have a standardized behavior management program?

Answer: This question needs clarification.
Basically, behavior management programs are individualized to the resident.

7. <u>Consultation recommendation for newly hired Activity Directors</u>

Newly hired Activity Directors who have no previous healthcare/long term care or related experience have 6 months to complete the state approved 90-hour activity course. In the meantime, what does

the ISDH recommend in terms of providing activity consultation until the staff member has successfully completed the course?

Answer: 410 IAC 16.2-3.1-33 (f) requires after July 1, 1984, any person who has not completed an activities director course approved by the division and is assigned responsibility for the activities program shall receive consultation until the person has completed the course.

8. Dating of MDS supportive documentation

Describe how MDS supportive documentation should be dated.

Answer: MDS supportive documentation guidelines are outlined in the July 20, 2004 Provider Bulletin. Questions regarding supportive documentation guidelines should be directed to the EDS/ Long Term Care Unit at (317) 488-5089.

9. Ongoing activity programs in Dementia/Alzheimer units

For facilities with specialized Dementia/Alzheimer units, what is the regulatory requirement for ongoing activity programs?

Answer: The activities must meet the needs of the residents.

10. Residents from the criminal justice system

For facilities that have admitted residents from the criminal justice system, what would the ISDH expect to see in terms of documentation & follow up with probation officers, court proceedings and/or criminal history information?

Answer: The IDH has no expectations in regard to documentation and/or follow-up with probation officers, court proceedings and/or criminal history information involving a resident admitted from the criminal justice system. The ISDH's expectation is that a pre-admission screening would identify any personal histories of those residents that would render them at risk for abusing other residents, or in some cases, visitors, and that the facility has developed interventions to prevent occurrences, monitored the resident for changes that trigger particular behavior, and reassessed the interventions on a regular basis to ensure the on-going effectiveness of the intervention strategies.

As far a maintaining contact with a probation/parole officer, court, or ensuring that a convicted sex offender is on the "list", that would be the responsibility of the resident's responsible party, power of attorney, or guardian. If the resident has no such representative, and is unable to be his own responsible party, then social services may need to be involved in obtaining such representation for the resident.

11. Definition of "regular contact" under the new dementia rule

Please clarify "regular contact" with residents under the new dementia training rule. In a CCRC where you have a lot of high school age food service employees who work as servers, this six-hour training rule would be a challenge due to frequent turn over.

Answer: Regular contact is a staff member who is likely to come in contact with residents in the normal course of their job duties.
Source: August 10, 2004 letter regarding Dementia Care training
Dementia Care training information is available at:
http://www.in.gov/isdh/regsvcs/ltc/alzinfo/index.htm

12. Emergency water requirement

Please clarify the emergency water requirement. Has an amount required for each resident been specified? Our understanding is that there is no specific amount required by rule.

Answer: No specific amount of water is required by rule or regulation, but the facility must have a written protocol which defines the method of estimating the volume of water required. The January 2000 LTC Newsletter specified a method that could be used to estimate the volume of water. 410 IAC 16.2-3.1-19 (f)(1) & F466 require: The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.

Insert 4

Life Safety Code 2000 Edition
Questions & Answers

Centers for Medicare & Medicaid Services

Midwest Consortium

Life Safety Code 2000 Edition

Questions and Answers
Last Updated 02/11/05

Note from the Editor: The information contained in the following Qs and As should be considered final, but may be updated to include additional technical information.

Three year phase-in guidance, roller latches, emergency lighting

Question #1: We would like guidance on how CMS would expect us to document and track three year phase in citations (i.e., emergency lighting). We have already cited these violations and facilities are requesting more than the normal allotted 90 days before penalties are imposed. How will we document these citations when a facility requests the full three years for correction?

Answer #1: Cite the deficiency on each survey. Facilities should then submit an acceptable plan of correction. These deficiencies in LTC facilities should be assigned a scope and severity of A, B, or C. Monitor the progress (or lack of progress) at each Recertification Survey until the work is complete. You should also use this process for roller latches. However, the doors must be positive latching and emergency lighting must be provided and operable.

Waiver correction

Question #2: We were previously advised us that, instead of deleting previously approved waivers, write on the CMS 2567, "Previous waiver now meets 2000 LSC." Questions have come up. Is this notation made in the general comments section of the 2567, or would a surveyor actually cite it by tag number, and then write under the tag number the above statement? If it is done by notation in the general comments, that seems to make sense. However, if it is done under a tag number, does this get data entered, and how? We're not sure why we should be noting it at all. This would appear that there is a deficiency when in actuality, it meets code. Our engineers tell me that we "drop" waivers all of the time with no specific notation of them.

Answer #2: The Surveyor should record this fact in the general comments data tag, 0000, on the CMS-2567 and in the Building/Wings section of the Survey Booklet for the first survey of each facility using the 2000 Code.

ICF/MR's – Waivers

Question #3: The state agency no longer has authority to grant waivers for ICF/MR facilities. The state will recommend waivers to CMS and CMS will grant waivers. How should the process work with waivers that have already been granted by the state agency? Should these now be written as initial waivers and we will process them through CMS for approval/denial based on our recommendation?

Answer #3: All requests for waivers of ICF/MR's surveyed under Healthcare should be submitted to the Regional Office for approval after each survey. (Waivers are not allowed per statute in ICF/MR's surveyed under the Board and Care regulations.) However, there is no need to submit all outstanding ICF/MR LSC waivers now. Waiver requests from these facilities should be submitted following the State's first survey of these facilities under the 2000 Life Safety Code.

LSC Conditions – hospital

Question #4: When LSC deficiencies are cited in a non-accredited hospital, can the state exercise more discretion in determining if a Condition is not met? In contrast, in an accredited hospital, with respect to Weekly Note #72, there may be only 1 deficiency that adversely affects the health and safety of residents and we will put the Condition out, however, in a non-accredited hospital, there may be several deficiencies not met and the

state agency may decide that the Condition is still met since the provider can pass, for example, the Fire Safety Evaluation System (FSES). We are asking for CMS clarification if this inconsistency is intended and accurate. Should we be treating non-accredited differently than accredited when it comes to citing these LSC deficiencies?

Answer #4: Due to the difference in the certification requirements for accredited versus non-accredited hospitals, you do have more flexibility in marking the LSC Standard and, as a result, the PE COP "not met" in non-accredited hospitals. For accredited, you cannot mark "Meets based upon…Acceptance of a Plan of Correction" until you get a POC. You can't get/require a POC until you remove their deemed status, which can only be done when you have marked the standard not met/PE COP not met.

Alcohol gel

Question #5: If we see alcohol sanitizer dispensers in the exit corridors during survey, are we to cite this?

Answer #5: Yes. Alcohol sanitizer dispensers are not allowed in exit corridors and are to be cited as a deficiency at either K73, K135 or K029 as appropriate. These sanitizers should be located within the resident room. See attached for additional information (prepared by Katharine Achor of RO VII).

Alcohol gel

Question #6: Earlier this year CMS provided direction/references for mounting of dispensers containing alcohol gel products in long term care facilities. The direction indicated while these dispensers were not permitted in egress corridors, they could be mounted in the room.

Last month, a Quality Measure update contained a note indicating that the executive committee of the Hospital Fire Marshals' Association (HFMA) has unanimously voted to support the installation of alcohol-based hand washing gels in corridors. HFMA said the committee compared the fire risk versus the risk of infection, and concluded the likelihood of a fire was minimal by comparison to the risk of spreading a life threatening infection. The organization said it looked at the history of fires in health care facilities and did not find an incident where the corridor was the area of fire origin. It also considered studies indicating hand gels are used more often when access to the gel is convenient to caregivers, and a study commissioned by the AHA's American Society of Healthcare Engineering that found dispensers of the gel not exceeding 1 liter could be safely installed in corridors as long as they were spaced intermittently and not in carpeted areas. The HFMA recommended that the fire code community revisit the applicable codes and change them to clear the way for acceptance by all of the authorities having jurisdiction. It also recommended facilities using the gels have automatic sprinklers."

I would like to know:

1) Has the CMS position issued previously changed? If so, when, and is the statement from the Quarterly Measure update the current CMS position?
2) Are long term care facilities located in hospitals allowed to have the dispensers located on corridor walls?

Answer #6: 1) No, our position has not changed. 2) No. In September 2003, the CDC issued instructions on the placement of these materials and they recommended placing these gels in patient/resident rooms near the entrance and not in egress corridors where they could be considered a fire hazard. CMS fully supports the recommendation that alcohol gels not be placed in egress corridors.

I am attaching CDC recommendations on this issue that are dated September 12, 2003.

I hope you find this helpful. Let me know if you have questions.

Liquid Oxygen

Question #7: May liquid oxygen tanks be refilled in a resident's room?

Answer #7: As stated during the FY 2000 Life Safety Code Satellite Broadcast on October 9, 2003, the transferring/transfilling of oxygen containers in resident bedrooms is prohibited by NFPA 99 and is to be cited as a deficiency at K143.

According to the NFPA 99, 1999 edition:

Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:

c) Separated from any portion of a facility where patients are housed, examined or treated, by a separation of a **fire-barrier of 1-hour fire resistive construction;** and

b) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and

c) The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted.

NFPA 99 continues to state that transferring shall be in accordance with CGA Pamphlet P 2.6 and comply with pamphlet P2-7 . It has been alleged that these pamphlets permit filling in patient rooms. This is not correct. The pamphlets state how to fill, but not where to fill.

NFPA staff has advised us that filling must be done in accordance with the 3 criteria listed in section 8-6.2.5.2. As the Authority Having Jurisdiction, we concur with their opinion.

Oxygen is not to be transferred from one container to another in patient sleeping rooms, and such transferring must take place only in rooms protected in accordance with section 8-6.2.5.2 as listed above.

Alcohol gel

Question #8: Must there be secondary "No Smoking" signs in the vicinity of Oxygen tanks in "Smoke free" facilities?

Answer #8: Under the 2000 LSC, in health care occupancies where smoking is prohibited –and strictly enforced - and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking are not required in areas of administration. Signage is still required in areas where transfilling is allowed.

Single station smoke detectors

Question #9: What are the maintenance and testing requirements for single station smoke detectors placed in resident rooms with unrated furnishings brought from home?

Answer #9: The 1999 edition of NFPA 72 at 7-3.3 indicates in part "Single station detectors installed in other than one-and-two family dwelling units shall be tested and maintained in accordance with Chapter 7. Section 7-4.1 indicates that "fire alarm system equipment shall be maintained in accordance with manufacturer's instructions." Most single station detectors have a test button which says "test weekly."

Range hood – fire alarm connection

Question #10: Is it correct that the range hood needs to be interconnected to the fire alarm system? If so, do you have any tips on how surveyors can verify the connection? Most commercial range hood inspection forms I have seen make no note about an interconnection and short of taking a facility's work for it we are not sure how to go about verifying.

Answer #10: Yes. NFPA 1998 edition of NFPA 96, 7-6 System Annunciation
7-6.1.
Upon activation of an automatic fire-extinguishing system, an audible alarm or visual indicator shall be provided to show that the system has activated.
7-6.2
Where a fire alarm signaling system is serving the occupancy where the extinguishing system is located, the activation of the automatic fire-extinguishing system shall activate the fire alarm signaling system.

Every initiation device or special hazard device (the range hood could be either) should be listed on the annual fire alarm paperwork. If it is not listed, then you could use this as your evidence. The fire alarm testing and maintenance paperwork is a legal document and should be complete with every item checked with a yes, no, not applicable or a line drawn through a section. Citations could be made at K52. This tag would cover both the failure to install the system in accordance with NFPA 72 (1999) as well as the maintenance, inspection, testing and records requirements at 7-5.2, which requires that all devices are listed.

Corridor width - obstructions
Question #11a) Under the 2000 LSC, 19.2.3.2 states exit corridors shall not have less than four feet clear width. Can we allow portable equipment placement in corridors if they meet the following criteria? Non-hazardous/nonflammable items, wheeled, mobile items (i.e. resident lifts), not including trash/soiled linen containers of a greater size or density as required by the code and all items are stored on the same side of the corridor. Staff is trained to include recognition and manner of removal in an emergency, and the clear width is never less than four feet.
Question #11b) We are running into facilities that are putting crash carts and isolation carts in the corridors. These corridors are 8 foot and have no alcoves to place the carts in. The most prominent situation is with the isolation carts that they need at each residence room. They advise that they need to have them directly available and cannot have them in the resident room.

Answer #11: You cannot shrink the corridor width if the facility was required to be constructed to a greater width. If the facility was constructed when the width was required to be 8 feet, the facility must maintain that 8-foot width even with the 2000 edition of the LSC being adopted. The exception is that you can have things in use in the corridor and that does not constitute a narrowing of the corridor. The storage of things in the corridor does narrow the corridor width and prohibits residents from being able to use handrails.

The appendix note talks about "storage" vs. "not in use." CMS interpretation says that storage is something not in attendance or not in use for over 30 minutes. If the appropriate staff is around (not on break) and using something every 30 minutes in the hall it is acceptable.

There is an exception that allows crash carts in the hall and small, wheeled isolation carts are acceptable for temporary use with items such as gowns and gloves while the particular room is under universal precautions. “Temporary” in this instance is that the unit is not dedicated to the care of individuals under isolation. Facility staff should trained in the identification and method of removing these items in the event of an emergency and should also be addressed in the fire plan.

We understand the issues involved as they are common to many facilities but it is also a function of the proper design of a facility to include storage areas for these purposes.

Sprinkler head recall

Question #12: Survey and certification memoranda 02-16 and 02-24 dealt with the sprinkler head recall and implied this would be completed within a year or two. We're still hearing that providers have difficulty getting replacements from the suppliers. Any new advice on this, or do we simply look for evidence that the provider is making good faith attempts to correct, has contacted the supplier, and is awaiting delivery/installation?

Answer #12: Replacing recalled sprinkler heads has been a problem in some areas, where the contractor cannot get to the facility within a year (or even longer). If the provider is making good faith attempts to correct, then that is enough. For example, if, in a certain area, ten providers had their sprinkler heads replaced and one did not, that one provider was likely NOT making a good faith attempt to have the heads replaced.

Range hood

Question #13: Should a facility replace the hood system, if it is out of date but has not discharged? Are you allowing them until 2006?

Answer #13: No, the only things that are allowed until 2006 are the emergency lights and roller latches – unless you have an emergency light or roller latch that does not function and then the facility must correct the violation within the enforcement guidelines.

A dry-chemical suppression system must be changed to meet UL-300 when the hydrostatic testing is due or if the system is dumped. A UL-300 system must also meet requirements in NFPA 96 and NFPA 17A – such as hood requirements, fan controls, shut off valves, and emergency notification requirements.

It should also be noted that if a facility changes out kitchen appliances, the new installation of these appliances under an existing hood should also meet the current code standards of UL-300. Here are some things to look for that are unacceptable practices and should be reported to your Fire Marshal's office:

- We have found some service companies that have removed the dry chemical, completed the hydrostatic test and then replaced the dry-chemical back into the system.

- Some companies have also required the purchase and placement of a K extinguisher to meet UL-300 requirements. The K class extinguisher should not be used with a dry-chemical system.

Anesthetizing locations – battery-powered lights

Question # 14: We were wondering if a ruling was ever made regarding the anesthetizing locations and the battery powered back up lights. The code states "in INHALATION therapy" only. It does not state "IV drip." Are the battery-powered lights required in ALL anesthetizing locations or just those that use inhalation therapy?

Answer #14: Yes, it is CMS's position that all anesthetizing locations have battery-powered lights.

Electronic locks

Question #15: Recently there was talk that electronic door locking mechanisms did not have to be tied to the fire alarm. Reviewing the NFPA codes, it appears to me that nothing has changed regarding the requirement

that electronic door locks must be tied to the Fire Alarm. Comments?

Answer #15: This is often misunderstood. Yes, if you have door locking it must be hooked to the fire alarm. However, the part that is misunderstood is the part that says
delayed egress shall be **permitted**. Not required, but permitted. You do NOT have to use delayed egress, but if you do so, the requirements in the Code must be met.

Fire alarm transmission/FSES

Question #16: One of the new healthcare requirements in the 2000 LSC has to do with the fire alarm sending a signal to a central station. Can a facility use the FSES to "get out" of this requirement?

Answer #16: Off-site fire alarm transmission has been required in healthcare occupancies by each edition of the Life Safety Code, (LSC) NFPA 101 since the 1973 edition and is a routine part of fire alarm and fire protection systems CMS in adopting the 2000 edition of the Life Safety Code which requires that existing health care facilities fire alarm systems to transmit off-site was discussed in the adoption of the 2000 LSC. CMS concluded that it was a necessary requirement to protect the health and safety of the residents and that healthcare facilities are expected to meet this requirement. This was reiterated in a letter S&C 03-23 dated May 8, 2003.

Although, one way of reaching equivalency to the provisions of the LSC is by using the Fire Safety Evaluation System (FSES), NFPA 101A, and *Guide on Alternative Approaches to Life Safety*, 2001 edition. This would not be an appropriate use of the FSES in this case.

The FSES was developed by the National Bureau of Standards at the request of the Department of Health and Human Services (DHHS) as an alternative method of determining compliance with the LSC. Facilities that pass the FSES may be certified for participation in the Medicare/Medicaid program even though they have repeat deficiencies reflected on the CMS-2786. The following guidelines should be observed when using the FSES:

- Only structural deficiencies that would be difficult or impossible to correct should be considered for FSES.
- Waivers and FSES processes should not be combined.
- The FSES may be applied only to buildings that conform with the LSC Worksheet 4.7.10, Facility Fire Safety Requirements Worksheet, items A through L, or Worksheet 7.7.6, items A through E, if applicable, or when a Plan of Correction (POC) for nonconforming items is accepted by the fire authority.
- The FSES can be used in facilities with many deficiencies or with a few costly deficiencies.

To use the FSES to "get out" of fire alarm transmission would not conform to the requirements for use and would also be a time consuming survey for a deficiency that is not structural and that is not impossible to correct. To allow this would be a misuse of the original intent of the FSES process.

(Q&As #17 – #30 pertain to Liquid Oxygen - LTC-Chapters 4 and 8)

Question #17: Is the intent to include the quantity of liquid oxygen storage containers in use as part of the sum total of liquid oxygen in storage in the facility?

Answer #17: No, only as it pertains to containers being stored.

Question #18: Is the intent to prohibit bulk supply storage of liquid oxygen in the amount of 20, 000cf per smoke compartment or per floor or per wing or per facility?

Answer #18: If a facility has bulk storage in excess of 3000 ft3 or 20,000 cubic feet within the facility, then the facility is required by NFPA 99, 4.3.1.1.2 to meet NFPA 50 Standard for Bulk Oxygen Systems. This requires that the oxygen be stored outside or in a building used only for the purpose of oxygen storage.

Question #19: Is the intent to define storage as personal use containers throughout the facility not connected to a patient for a period of time greater than one (1) hour?

Answer #19: In use is defined as anything that is in the process of being used or that which is used every 30 minutes.

Question #20: Is the intent to not require posting of oxygen signage when a containers is part of the nursing home emergency response cart?

Answer #20: Secondary signage or the posting of "No smoking – oxygen in use" is required if facility allows smoking. All other signage requirements still apply, such as posting locations of oxygen storage or transfilling areas, regardless if smoking is prohibited or not.

Question #21: Is the intent to limit the number of liquid oxygen containers in use in a single sleeping room?

Answer #21: Yes, to the extent that the facility meets the requirements at chapters 4 and 8 of NFPA 99.

Question #22: Is the intent to limit the number of persons in a single sleeping room requiring use of liquid oxygen containers?

Answer #22: No, it is not intended to limit the number of persons using liquid oxygen.

Question #23: Is the intent that all persons of a sleeping room are educated in oxygen use and safety?

Answer #23: Yes, if capable of being trained and educated.

Question #24: Is the intent that documentation of patient education for oxygen use and safety is maintained?

Answer #24: It would be in the best interest of the facility to keep this documentation, however it is not required by NFPA.

Question #25: Is the intent that liquid oxygen containers in use becomes liquid oxygen in storage once the connection to the user/resident is discontinued?

Answer #25: Yes, if oxygen is no longer being used by resident at least every 30 minutes. Additional consid-

eration should be given as long as the oxygen is supervised/attended, for instance in a physical therapy room.

Question #26: Is the intent to limit the size of the liquid oxygen containers in a resident sleeping room?

Answer #26: Yes, to the extent that the facility/room can meet the safety precaution requirements at Chapters 4 and 8 of NFPA 99.

Question #27: Is the intent to limit the number of liquid oxygen containers maintained at bedside per bed in a sleeping room?

Answer #27: Yes, to the extent that the safety precautions at chapters 4 and 8 of NFPA 99 are met.

Question #28: Is the intent to require securing (stand, chain rope or other device) of liquid oxygen containers in use in a sleeping room?

Answer #28: Yes, all oxygen containers, in use or in storage shall be secured in accordance with NFPA 99, Chapter 4 and the Basic LSC training manual SM M4L-19.6.

Question #29: Is the intent to require securing of liquid oxygen containers in oxygen storage rooms?

Answer #29: Yes, all oxygen containers, in use or in storage shall be secured in accordance with NFPA 99, Chapter 4 and the Basic LSC training manual SM M4L-19.6.

Question #30: Is the intent to require physical separation of the full liquid oxygen containers from the partial or empty liquid oxygen containers in the oxygen storage room?

Answer #30: Yes, all empty and full oxygen cylinders shall be stored physically separated. Refer to NFPA 99, Chapter 4 and the Basic LSC training manual SM M4L-19.6.

K146 – generator fuel source

Question #31: K-146 Surveyors were advised that the CMS policy is that natural gas is not a reliable source of fuel for a required generator. The exception would be if the utility company will provide in writing a guarantee that their service would never be interrupted. If this is the case, this will cause a major uproar in Michigan as many generators have over the years been switched over to natural gas. I do not see a utility guaranteeing that their service will never be interrupted.

Answer #31: This is not a policy of CMS, but a requirement of the 1999 edition of NFPA 110, chapter 3-1 for a Level 1 generator.

3-1 Energy Sources.
3-1.1
The following energy sources shall be permitted for use for the emergency power supply (EPS):
(a) * Liquid petroleum products at atmospheric pressure
(b) Liquefied petroleum gas (liquid or vapor withdrawal)

(c) Natural or synthetic gas
Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage, or a demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source.

Clearance for sprinkler heads

Question #32: I would like to have clarification on perimeter stacking and the 18-inch clearance required for sprinkler heads. I have encountered open shelves along the wall with notebooks or items stored on the shelves. The shelves are not built-ins with doors, just boards attached to the wall with stuff kept on them. Is this ok or should the 18-inch plain across the room be maintained?

Answer #32: Yes, the 18-inch clearance from the bottom of the sprinkler head should be maintained across the entire room/closet.
Exception:
NFPA 13 A-5-6.6
The 18-in. (457-mm) dimension is not intended to limit the height of shelving on a wall or shelving against a wall in accordance with 5-6.6. Where shelving is installed on a wall and is not directly below sprinklers, the shelves, including storage thereon, can extend above the level of a plane located 18 in. (457 mm) below ceiling sprinkler deflectors. Shelving, and any storage thereon, directly below the sprinklers cannot extend above a plane located 18 in. (457 mm) below the ceiling sprinkler deflectors.

Scope and Severity/Downgrading

Question #33a: When you give a S/S level for ISOLATED "D" and the facility shows that they are working on the deficiency, are you are permitted to drop the S/S?

Question #33b: We have a facility that was cited in mid February for not having the range hood system connected to the fire alarm. Our revisit will be around mid April.

This facility is in process of completely upgrading the fire alarm system with work beginning the first of April and completed by the end of April. Facility said they have and can/will produce documents from their fire alarm contractor showing that connection of the range hood system to the fire alarm is part of the upgrade.

In this situation, do you feel it inappropriate to lower the citation to the substantial compliance level? Pushing the revisit back would not work because we would run into problems with the 70th day. What would we accomplish by leaving them out of compliance? The denial date (90^{th} day) would not occur until after the upgrade to the fire alarm system was completed.

Answer #33: It is not appropriate to downgrade the S/S of any tag based upon a plan of correction, unless substantial compliance has been achieved and verified, or on revisit, it is determined that the s/s has actually changed. This has been misused in the past, as a way to extend to a facility additional time to complete corrections. From a fire inspector's liability point of view, it would be unwise to report that a facility is in substantial compliance, when in fact the facility is not – in the event of tragedy, I would not want to be in that position.

A possible example of when it may be appropriate - a facility has 10 doors that are not positive latching and they are cited a deficiency at an F. At the time of the revisit they have replaced 6 doors. They provide you documentation that 2 more are on backorder. It would not be appropriate to say the facility is in substantial

compliance, but it would then be appropriate to rewrite the deficiency, because substantial compliance has not been achieved, but change the S/S from an F to a D.

If a facility has to correct a deficiency that will obviously take longer than the allowed time, then a temporary waiver should be requested. Some examples of deficiencies that may take longer to fix – upgrading, installing or repairing a fire alarm, sprinkler system, or range hood; sidewalks cited in December in northern climates, and construction type deficiencies. From a customer service standpoint, it would be advisable to mention to a facility that they could ask for a waiver in the POC. They should explain in detail what would be accomplished in a given timeframe and they should keep the SA apprised of progress and delays. In some cases the facility may also need to implement additional safety measures while they work on the deficiencies. CMS is willing to grant 'construction' waivers, and the norm seems to be between 6 months to 1 year, depending on the situation.

The other option is to impose sanctions if the facility does not complete corrections within the timeframe they gave in the POC, just as you would a healthcare deficiency. The facility is to be in compliance with all regulations at all times, including LSC.

We teach the Basic LSC class to review the definitions of the harm levels and choose the scope based on the numbers of occupants who are affected.

Level 1 or S/S of A-C: A poor practice that the facility has with regard to paperwork – when we have investigated the issue and know that a maintenance practice is done, but is not documented correctly. An example might be that a facility is completing monthly fire extinguisher checks, records the inspection in a maintenance manual, but fails to document the checks on the fire extinguisher tag. This is not to say that all paperwork deficiencies belong at level 1 or that only paperwork deficiencies are assigned level 1 severity.

Level 2 or a S/S of D-F: Most deficient practices with regard to fire safety fall in this category as most issues do not harm the residents, but have the potential to do so.

Level 3 or S/S of H-I: Rarely used in LSC deficiencies because if a practice has caused harm in the fire safety arena, then it is most likely immediate jeopardy.

Level 4 or S/S of J-L: These issues are the ones that the threat to life is imminent or have the potential to cause egregious harm or death to the occupants of the building – fire alarm or sprinkler system not working, boilers in such poor repair as to cause an explosion hazard, blocked exits, or emergency generator malfunction and the facility accepts residents on life support. See Appendix Q of the State Operation's Manual.

These are only potential examples and every deficient practice needs to be evaluated on its own merits, on a case-by-case basis. No two deficiencies are ever the same. If you have questions about scope and severity, please contact your RO.

Door Swing

Question #34: Does the lack of addressing existing same swing smoke doors that do not swing in the direction of egress mean the 2000 Edition of 101 in Health Care occupancies no longer allows this condition? If so, would this be a waiver item, or does it in some way meet the code? I have not as yet found any direction or position indicated in the code. Some of our surveyors are now writing this condition as a K32 cite, because it can create a dead end corridor with no acceptable access to exit. Please advise.

Answer #34: Section 19.3.7.6, page 165 says, "*Such doors in smoke barriers shall not be required to swing*

with egress travel."

Section 18.3.7.5 indicates cross-corridor openings in smoke barriers shall be protected by a pair of swinging doors or a horizontal sliding door complying with 7.2.1.14. *Swinging doors shall be arranged so that each door swings in a direction opposite from the other.*

Therefore, existing doors do not need to swing with exit travel and new ones do.

3-Bin Trash/Soiled Linen Containers

Question #35: We have a three-bin laundry container. Each bin has a hanging container with a plastic flip top. Each container is less than 32 gallons, but combined the total capacity would be over 32 gallons. They are separate containers with separate lids but have a three-bin rack that the bags hang in..... Is this considered to be a container over 32 gallons? May this be stored in the corridor? May we restrict the use to only two of the three bins to avoid having to store in a hazardous area?

Answer #35: Yes, this is considered to be over 32 gallons. Per K75, this container would have to be located in a room protected as a hazardous area, according to 18/19.7.5.5

However, if the bin is 'in use', or it is attended and used no less than every 30 minutes, then this scenario would be acceptable. So, if you have containers larger than the 32-gallons and they are in use when staff make rounds, then this would be okay. As soon as they are done the container must be placed in a room protected as a hazardous area.

For storage in a non-hazardous area:
If there are three 15-gallon drums connected, and staff only use two of the drums, that would equal 30 gallons. Then the facility would need to remove one of the containers, as there would be a potential to fill all of them.

Waivers – Not Permanent

Question #36: Are all waivers issued as time-limited and subject to re-cite and re-review each year?

Answer #36: That is correct. There is no such thing as a permanent waiver. A facility is cited every time there is a survey, until the deficiency is corrected. Facilities who have received a waiver or an FSES equivalency are NOT in compliance - they are still non-compliant with the prescriptive requirements until the deficiency is corrected.

Posting of Survey Results F167

Question #37: Where can the requirements be found for posting life safety code surveys?

Answer #37: F167 states:

"A resident has the right to--

1) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents and must post a notice of their availability; and…"

The Guidelines for F167 state:

Guidelines: §483.10(g)(1)-(2)

"Results of the most recent survey" means the Statement of Deficiencies (HCFA-2567) and the Statement of Isolated Deficiencies generated by the most recent standard survey and any subsequent extended surveys, and any deficiencies resulting from any subsequent complaint investigation(s).

"Made available for examination" means that survey results and approved plan of correction, if applicable, are available in a readable form, such as a binder, large print, or are provided with a magnifying glass, have not been altered by the facility unless authorized by the State agency, and are available to residents without having to ask a staff person.

"Place readily accessible to residents" is a place (such as a lobby or other area frequented by most residents) where individuals wishing to examine survey results do not have to ask to see them.

Facilities are required to have both a health and a life safety survey to enter/remain in the program. In order for this requirement to be met, both the health and the fire safety surveys should be posted.

Fire Extinguisher Signage

Question #38: Are you aware of any requirements for fire extinguisher cabinets to be labeled? Obviously, you want building occupants to be able to find/easily identify extinguishers but does the cabinet have to have any type of "signage." I can't find anything in NFPA 10 covering this.

Answer #38: NFPA 10 1.6.12 does say that fire extinguishers have to be conspicuously marked. CMS considers the very nature of an extinguisher hanging openly on a wall to be conspicuous. Recessed fire extinguisher cabinets according to the NFPA can be labeled in any manner – and does not need to be visible from the ends of a corridor.
We are aware of OSHA requiring the signs to be visible from both directions, however this is not an NFPA requirement. Life Safety Surveyors are not responsible for the enforcement of OSHA requirements, but this is a good practice to inform facilities about.

Sprinklers in Closets

Question #39: What are the requirements for sprinklers in closets?

Answer #39: NFPA 13, Section 4-1.1, states that a building with sprinklers installed throughout is considered fully sprinklered. CMS policy classifies freestanding wardrobes as furniture and does not require them to be sprinklered. However, closets and wardrobes that are permanently affixed to the wall must be protected by sprinklers; the sprinkler heads need not necessarily be inside the closet. The closet may be covered by a sprinkler head that is located outside of the closet if: the top is removed off the wardrobe or if the closet doors have louvers or screen doors. Two or three sprinkler heads may also be provided outside the closet as a water curtain. In your survey, you should determine whether the closet/wardrobe has a small enough fuel load that a fully developed fire that cannot be controlled by the heads outside the closet/wardrobe is unlikely to occur.

K38 Hard path to a public way **11/29/04**

Question #40: Do walk ways to the public way have to be an all weather surface? Correct me if I'm wrong, but I believe this has changed with the new code as not being
required under 7.7.1. A7.7.1 specifically says that grass or similar surfaces are acceptable as long as there being enough space to accommodate all occupants. Any clarifications on this would be greatly appreciated.

Answer #40: Regarding the citation involving the lack of a suitable exit path to a public way, Section 7.7 of

the 2000 LSC Handbook does indicate that a path as simple as grass may be allowable in some cases. This application could be construed as acceptable for normally mobile individuals; however, residents in health care settings required to rely on assistive support or wheeled devices during evacuation may need a more substantial walking surface. In a health care setting, the terrain outside of a facility, the safe distance to get away from a building to a public way and extreme weather conditions must be taken into consideration. The paramount consideration (especially in the mid-west) is whether the exit path of travel can be easily maintainable and usable under all weather conditions.

The interpretive letter referenced for this deficiency, as previously stated, is still applicable (although the tag has changed from K32 to K38 with the adoption of the 2000 code) even though it is more than ten years old and agreeably somewhat inconsistent with the current 2000 LSC language. Surveyors may have to reconsider their view on the appropriateness of exit paths when visiting facilities to determine if all exits are fully available and adequate under all weather conditions. This does not mean, in all cases, formal concrete or blacktop materials may be necessary or required. Other alternative materials may suffice if the path can be easily maintained and safely traversed throughout the year.

Waivers and the FSES:

Question #41: We were told at the last Fire Safety Evaluation System (FSES) training that a facility may receive a waiver of a requirement on Table 8 of the FSES evaluation form and still pass the FSES. Is this true?

Answer #41: CMS has come to the agreement that a facility **MUST** meet all of the requirements on Table 8 of the FSES form, without any waivers of those items, in order to pass the FSES. If a facility does not meet all the requirements of Table 8, then they may request a waiver of that requirement but they **CANNOT** be deemed in substantial compliance based on the FSES. In summary, a facility can only be surveyed under the FSES if they meet all Table 8 requirements without the use of a life safety code waiver.

Insert 5

Centers for Medicare and Medicaid Services
Survey & Certification Letter
S&C-04-37
Residents of Long-Term Care (LTC) Facilities Who Receive
End Stage Renal Disease (ESRD) Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-04-37

DATE: **July 8, 2004**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Addendum I to S&C Letter 04-24 on the Care for Residents of Long-Term Care (LTC) Facilities Who Receive End Stage Renal Disease (ESRD) Services

Letter Summary

- S&C Letter 04-24, issued March 19, 2004, clarified certification requirements and coordination of care expectations for residents of LTC facilities who receive ESRD services.

- This addendum to that letter includes as an attachment follow-up Questions and Answers (Qs &As) regarding the scope of the guidance and the responsibilities of the providers.

On March 19, 2004, we issued S&C Letter 04-24. This letter was developed to provide clarification regarding the expectations and approval process for facilities that intend to offer care for residents in a LTC facility. The issuance of S&C Letter 04-24 stimulated questions about the scope of the guidance, responsibilities for service and care, and survey procedures related to this service. In this addendum, we provide answers to the questions that have emerged. The Qs and As follow as an attachment.

Effective Date: Immediately

Training: The information contained in this announcement should be shared with all survey and certification staff, their managers, and the state/RO training coordinator.

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Attachment

Follow-up Questions and Answers to S&C Letter 04-24 on the Care for Residents of Long-Term Care (LTC) Facilities Who Receive End Stage Renal Disease (ESRD) Services

Bases for Guidance:

Q1. What are the bases for the guidance for ESRD facilities and LTC facilities detailed in S&C Letter #04-24?

A1. The guidance specified in S&C Letter #04-24 reflects current requirements specified ESRD regulations at 42 CFR §405.2100 and LTC facility regulations at 42 CFR §483. ESRD facilities are required to meet the Conditions at §405.2130 through §405.2163 unless otherwise specified by the regulations. LTC facilities are required to meet the regulations at §483.

Relationship to Rules:

Q2. What is the relationship between the policy memo guidance and current rules?

A2. S&C Letter # 04-24 provides guidance to state and federal surveyors in applying existing regulations. There are no new regulations in the letter. S&C Letter #04-24 organizes existing regulations in a single document for added convenience. The letter then provides guidance to surveyors in the application of those regulations.

Locating Form CMS-3427A:

Q3. Where do we locate Form CMS-3427A that is to be used for applicants seeking approval to provide ESRD services in a LTC facility?

A3. Applicants should use Form CMS-3427. Form 3427A is no longer in print.

Application to Hospital-based Nursing Homes:

Q4. Do the ESRD and LTC survey protocols in this letter apply to hospital-based nursing homes that offer outpatient dialysis services to residents with ESRD?

A4. Yes. The survey protocols apply to all nursing home facilities that offer home dialysis to residents whose dialysis services are paid under the Medicare ESRD Part B benefit. If the dialysis care is not covered under the Medicare ESRD program, then care may be reviewed in a different manner.

Agreement between Durable Medical Equipment (DME) Supplier and a Nursing Facility:

Q5. For patients using Method II, is a written coordination agreement required to specify respective responsibilities between the DME supplier and the nursing facility?

A5. No, an agreement is required between an ESRD facility and a LTC facility, and between the DME supplier and the ESRD facility. The DME supplier is responsible to and reports to the ESRD facility regarding the provision of supplies and equipment in the LTC facility. The DME supplier does not need to have a formal relationship with the LTC facility.

Types of Facilities Covered by Guidance:

Q6. What facilities are covered by S&C Letter #04-24? Are intermediate care facilities for persons with mental retardation or related conditions (ICF/MR) facilities covered?

A6. This guidance is directed to dialysis in nursing homes only. In the future, we will describe requirements and expectations regarding dialysis in other types of care facilities. In this guidance we used the terminology “long-term care facility” because the regulations at 42 CFR §483, Subpart B, Requirements for Long Term Care Facilities use this terminology in referring to nursing homes. In §483.5 a facility is defined as "a skilled nursing facility (SNF) that meets the requirements of sections 1819 (a), (b), (c), and (d) of the ACT, or a nursing facility (NF) that meets the requirements of sections 1919 (a), (b), (c), and (d) of the ACT...." but does not include an institution for persons with mental retardation or with related conditions described in §440.150 [Intermediate Care Facility (ICF/MR) services] of this chapter.

States Allowing Dialysis in LTC Facilities:

Q7. Are states required to allow home dialysis in LTC facilities?

A7. No, states may have requirements that prohibit the introduction of home dialysis into LTC facilities in their states. According to §405.2135, the ESRD facility must be in compliance with applicable Federal, State, and local laws, and regulations.

One Patient per Machine:

Q8. What actions should be taken if more than one home dialysis patient is using a single machine in a LTC facility?

A8. Reimbursement for home dialysis therapies is based upon one machine per patient. If more than one home dialysis patient is using a single machine, the respective CMS Regional Office should report this to the appropriate Fiscal Intermediary.

Monitoring of and by Licensed Health Professionals:

Q9. What are the responsibilities for monitoring the capabilities of the licensed health professionals? What is the expectation of the ESRD-experienced licensed health care professional?

A9. Facilities, including their governing bodies and physician directors, are responsible for ensuring that appropriate and adequate staff are hired, trained, and supervised. ESRD regulations at §405.2136 and §405.2161 define the staff monitoring relationships of the governing body and the physician-director. ESRD regulations require that whenever patients are undergoing dialysis, one currently licensed health professional (e.g. physician, registered nurse, or licensed practical nurse) experienced in rendering ESRD care is on duty to oversee ESRD patient care. The preamble language for this section recognizes that "this regulation is a minimum requirement." Therefore, CMS expects that at least one of the above-mentioned professionals is on duty during dialysis.

Licensed health professionals also have responsibilities that are defined by state licensure requirements, state practice acts, state pharmaceutical acts, and other state laws that impact on professional practice, such as education laws.

Responsibilities of the Physician Director of the ESRD facility:

Q10. Does the Physician Director of the ESRD facility have any responsibility for patients being dialyzed in the nursing home?

A10. The ESRD Physician Director is responsible for oversight of care including responsibility for patients dialyzed in center and for all home patients. These specific responsibilities are found at §405.2136(f)(2), §405.2161(b)(3), and §405.2161 (b)(5).

Home Training Nurses Responsibilities:

Q11. Who is responsible for training the staff performing the dialysis treatments?

A11. The qualified home training nurse of the approved ESRD facility must be in charge of all home training both for home patients and for individuals who assist patients in home dialysis. The expectation of CMS is that the qualified home training nurse is directly responsible for all home training.

Nursing Home Social Worker and Dietitian:

Q12. Can the nursing home's staff social worker (MSW) and dietitian (RD) substitute for staff from the DME or the ESRD provider?

A12. No, the ESRD benefit includes support services from a "qualified" social worker (MSW) and a "qualified" dietitian (RD) provided by the ESRD facility.

Responsibilities for Medications:

Q13. Who is responsible for providing medications for the dialysis patient/resident?

A13. The ESRD and LTC facilities should delineate the responsibilities for the patients' medications in the written agreement. The LTC facility provides routine and emergency drugs for its residents. If dialysis drugs are maintained in the LTC facility pharmacy, applicable regulatory requirements for LTC apply. Erythropoietin (EPO) is provided to the patient by the ESRD facility. The safe and effective use of EPO by patients at home requires that the patient's dialysis facility or physician responsible for all dialysis-related services make a comprehensive assessment of the patient and the patient's needs at the time of selection for EPO therapy according to ESRD regulations at §405.2163(g).

Care in an Emergency:

Q14. In the event of an emergency, who is responsible for the patient while the patient is undergoing dialysis?

A14. The ESRD facility and LTC facility are expected to define responsibilities for emergencies in the written agreement. The ESRD facility is required to have specific policies and procedures for handling medical and nonmedical emergencies that threaten patient health or safety related to the patient's dialysis treatments. ESRD facilities are governed by regulations at §405.2136(f)(1)(v), 405.2136(g), and 405.2160(b) that require the facilities to have policies governing the care of patients in emergencies and to arrange for physician services and hospital services for emergency care.

Patient's Right to Select Treatment:

Q15. Do patients/residents continue to have the right to select a treatment method for dialysis?

A15. S&C Letter #04-24 reaffirms the patient's right to choose a modality and setting. These rights are regulated in both the care planning and patients' rights sections of the respective ESRD and LTC regulations.

Adequacy of Caregiver/Technician Training:

Q16. How will the adequacy of caregiver/technician training be assessed?

A16. Responsibility for oversight of caregiver/technician training for home dialysis in LTC settings rests primarily with the governing body and the physician director of the ESRD facility. The governing body of the ESRD facility [§405.2136(f)] must approve patient care policies concerning the provision of home dialysis support services. The physician director [§405.2161(b)(3)] is responsible for assuring adequate monitoring of the patient and the home dialysis process with periodic assessment of the performance of dialysis tasks.

ESRD Networks and Home Dialysis in LTC Facilities:

Q17. What responsibilities will ESRD Networks have for home dialysis in LTC facilities?

A17. Since these patients receive care through an ESRD facility that is under the purview of an ESRD Network whose role is defined by statute, these beneficiaries will be treated like other ESRD beneficiaries. ESRD Networks will undertake their statutory role with respect to quality improvement activities, data management, and grievance/appeals processing just as they do for other ESRD beneficiaries.

Role of LTC Surveyor regarding Appropriate Dialysis:

Q18. What are the expectations for LTC surveyors, many of whom do not have ESRD survey experience?

A18. The LTC surveyors are not expected to survey for appropriate dialysis treatments. ESRD surveyors will conduct the dialysis survey. The LTC surveyors are surveying the nursing home under current regulatory requirements as stated in the protocols. The LTC surveyors will observe care. If a LTC surveyor feels that there may be a potential problem, the surveyor will generate a complaint and referral to an ESRD surveyor.

Responsibilities of the LTC Medical Director:

Q19. Does the LTC medical director have to know anything about dialysis?

A19. Currently, residents with diagnoses of ESRD reside in LTC facilities. The LTC Medical Director is required to be in compliance with current regulations at 483.40 Physician Services and 483.75 (i) Medical Director. The regulatory requirement at 483.20(k)(2)(ii)- F280 states "A comprehensive care plan must be prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and *other appropriate staff* in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's

family or the resident's legal representative."

Since the resident has a diagnosis of ESRD and is receiving dialysis treatments, CMS expects that "other appropriate staff" includes the ESRD physician, ESRD nurse, ESRD social worker, and ESRD dietitian. It is expected that this coordination is outlined in the agreement between the ESRD facility and the nursing home.

Citation for LTC Medical Director:

Q20. Which LTC regulation is cited if there is a lack of compliance in areas of medical responsibility for the LTC Medical Director?

A20. The LTC survey team will cite F501 if the team has evidence that the facility is not in compliance with the regulatory requirement for the Medical Director. F501 Medical Director. (2) The medical director is responsible for –(i) Implementation of resident care policies; and (ii) the coordination of medical care in the facility.

Coordination of ESRD and LTC citations:

Q21. How do States with multiple survey agencies (separate agencies for LTC and ESRD) coordinate citations?

A21. Citations are not coordinated. Non-compliance with LTC requirements is cited at 42 CFR 483, Requirements for LTC Facilities. Non-compliance with ESRD Conditions of Coverage is cited at 42 CFR 405.2100. Since there are no alternative sanctions for ESRD regulations, LTC must be processed separately, using LTC guidelines and timelines.

Insert 6

Centers for Medicare and Medicaid Services
Survey & Certification Letter
S&C-04-41
Corridor Width & Corridor Mounted Computer Touch Screens in Health Care Facilities

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-04-41

DATE: August 12, 2004

TO: State Survey Agency Directors
State Fire Authorities

FROM: Director
Survey and Certification Group

SUBJECT: Corridor Width & Corridor Mounted Computer Touch Screens in Health Care Facilities – Clarification Effective Immediately

Letter Summary

- This letter addresses the issue of corridor mounted computer touch screens and their installation in health-care facilities.
- Corridor mounted computer touch screens, if properly installed, shall not be considered a corridor obstruction.
- Other items may be considered corridor obstructions.

The purpose of this memorandum is to clarify the Centers for Medicare & Medicaid Services' (CMS) policy regarding corridor width requirements and the installation of computer touch screens in health care facilities. CMS recently received several inquiries concerning the acceptability of corridor mounted touch screens and questions whether or not the touch screens installation interferes with requirements for corridor width in a health care facility. With the anticipated spread in the use of these devices this clarification is applicable to all health care facilities. These computer devices allow input into medical records such as the Minimum Data Set (MDS) or other online patient/resident records. The device in question is approximately 3.5 inches thick and is mounted approximately 60 inches above the floor.

Life Safety Code (LSC) requirements addressing corridor width and means of egress requirements are found at several locations in the LSC.

Section 7.3 of the LSC discusses general requirements:

- This section states that the width of means of egress shall be measured in the clear at the narrowest point of the exit. It has an exception that allows projections of not more than 3.5 inches on each side shall be permitted at 38 in. and below.

This is to allow for the installation of a handrail and for people to use the handrail without impediment.

Sections 18.2.3.3 and 19.2.3.3 if the LSC discuss specific health care requirements:

- These sections define the corridor width in new and existing health care facilities and that the corridor shall be arranged to prevent obstruction to the convenient removal of non-ambulatory persons.

The installation of these devices would not interfere with the overall corridor width requirements of the LSC and are permitted if the device when installed did not extend out from the corridor wall in excess of 3.5 inches. Locating the device at least 60 or more inches above the floor will prevent interference with individuals using the handrail along the corridor wall. No chairs, tables, filling cabinets or carts can be placed around these devices or in the corridor where these devices are installed which would reduce the width of the corridor to less than the width the corridor was originally constructed. In use (not left unattended for more than 30minutes) items such as linen carts, medication carts and janitorial equipment would not be included in these exclusions. Infection control supply cabinets outside of a specific room are allowed in the corridor while precautions are enforce for that room. Crash carts are allowed in the corridor for quick access in an emergency.

To evaluate compliance with these requirements, the surveyor should verify that:

- The computer monitor does not extend out more than 3.5 inches from the wall and is located at least 60 inches above the floor;

- No chairs, tables, filling cabinets or carts are located in the corridor where these devices have been mounted;

- The original corridor width has not been diminished by any chairs, tables, filling cabinets or any not in use carts or janitorial equipment or devices affixed to the wall that exceed 3.5 inches in thickness.

If you have further questions regarding this matter, please contact James Merrill at (410) 786-6998.

Effective Date: The information contained in this memorandum is current policy and is in effect for all healthcare facilities. Please ensure distribution by August 31, 2004.

Training: This clarification should be shared with all survey and certification staff, fire authorities, surveyors, their managers, and the state/RO training coordinator.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

Insert 7

Centers for Medicare and Medicaid Services
Survey & Certification Letter
S&C-05-09
Nursing Home Reporting Requirements for Alleged Violations of Mistreatment, Neglect, and Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-05-09

DATE:December 16, 2004

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Clarification of Nursing Home Reporting Requirements for Alleged Violations of Mistreatment, Neglect, and Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property

Issue:

The state survey agencies have asked the Centers for Medicare & Medicaid Services (CMS) to clarify the regulations at 42 C.F.R. §§483.13(c)(2) and (4). In particular, these sections address the facility's obligations to report allegations and the results of the investigation of these alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.

Background/Facts:

Below are the requirements related to 42 C.F.R. §483.13 Resident behavior and facility practices:

§483.13(c)(2): The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately (emphasis added) to the administrator of the facility and to other officials in accordance with State law (emphasis added) through established procedures (including to the State survey and certification agency).

§483.13(c)(3): The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

§483.13(c)(4): The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Discussion:

Nursing homes must comply with requirements for participation, including reporting requirements set out in 42 C.F.R. §§ 483.13(c)(2) and (4). No state law can override the obligation of a nursing home to fulfill the requirements under 42 C.F.R. §483.13(c), so long as Medicare/Medicaid certification is in place.

As specified in 42 C.F.R. §§ 483.13(c)(2) and (4), the following alleged violations and the results of all investigations must be reported to the administrator of the facility, other officials in accordance with state law, and the state survey and certification agency. These alleged violations are defined as follows:

- *Mistreatment* - (A definition is not provided at this time.)
- *Neglect* - Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness (42 C.F.R. §488.301).
- *Abuse* - The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish (42 C.F.R. §488.301).
- *Injuries of unknown source* - An injury should be classified as an "injury of unknown source" when both of the following conditions are met:
    - The source of the injury was not observed by any person **or** the source of the injury could not be explained by the resident; **and**,
    - The injury is suspicious because of the extent of the injury **or** the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) **or** the number of injuries observed at one particular point in time **or** the incidence of injuries over time.
- *Misappropriation of resident property* - The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent (42 C.F.R. §488.301).

The facility must follow the timeframes established in the regulations; that is, the facility must ensure that all alleged violations are reported immediately to the administrator of the facility and to other officials in accordance with state law through established procedures (including to the state survey and certification agency in accordance with 42 C.F.R. §483.13(c)(2), and the results of all investigations must be reported to the administrator or his/her designated representative and to other officials in accordance with state law (including to the state survey and certification agency) within 5 working days of the incident in accordance with 42 C.F.R. §483.13(c)(4).

CMS believes "immediately" means as soon as possible, but ought not exceed 24 hours after discovery of the incident, in the absence of a shorter state timeframe requirement. Conformance with this definition requires that each state has a means to collect reports, even on off-duty hours (e.g., answering machine, voice mail, fax).

The phrase "in accordance with State law" modifies the word "officials" only. As such, state law may stipulate that alleged violations and the results of the investigations be reported to additional state officials beyond those specified in Federal regulations. This phrase does not modify what types of alleged violations must be reported or the timeframes in which the reports are to be made. As such, states may not eliminate the obligation for any of the alleged violations (i.e., mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident property) to be reported, nor can the state establish longer time frames for reporting than mandated in the regulations at 42 C.F.R. §§ 483.13(c)(2) and (4).

State Survey Agency Action: State survey and certification agencies must ensure Medicare/Medicaid participating facilities are following these reporting requirements. Self-reported incidents should be managed and entered into the ASPEN Complaints/Incidents Tracking System (ACTS), in accordance with the instructions found in S&C-04-09*.

Effective Date: The information contained in this memorandum clarifies current policy and must be implemented no later than 30 days after issuance of this memorandum.

Training: This clarification should be shared with all survey and certification staff, surveyors, their managers, and the state/RO training coordinator.

/s/
Thomas A. Hamilton

cc: Survey and Certification Regional Office Management

Insert 8

Centers for Medicare and Medicaid Services
Survey & Certification Letter
S&C-05-13
Special Focus Facility Program
For Nursing Homes

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-05-13
DATE: December 16, 2004

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Improving Enforcement via the Special Focus Facility Program for Nursing Homes

Background

The Centers for Medicare & Medicaid Services (CMS) created the SFF program in 1998 as one of the initiatives of the Nursing Home Oversight and Improvement Program. The SFF program sought to decrease the number of persistently poorly performing nursing homes by focusing more attention on nursing homes with a record of poor survey performance. In January 1999, CMS directed state survey agencies (SAs) to conduct two standard surveys per year for each SFF instead of the one required by law. CMS also requested that states submit a monthly status report listing any surveys, revisits, or complaint investigations of SFF they had conducted in that month.

In this memorandum we convey revised methods that improve the selection of nursing homes for the SFF Program. We also strengthen enforcement of remedial action for those nursing homes that exhibit a persistent pattern of substandard care. The revisions will allow states to monitor facilities in need of more attention, impose sanctions on SFFs that fail to meet certain survey standards, and remove the monthly reporting requirement.

I very much appreciate the work of the state representatives who provided critiques of the current SFF program and specific ideas for improvement. Criticisms, and the corresponding CMS actions, are outlined below:

	Criticism	Improvement
1.	**Limited number of facilities:** There have been too few nursing homes selected in the large states (2), and too many in very small states (2 out of 14 in one state). Hence, one small state ends up picking 14% of the state's nursing homes while another state picks 0.5%).	The number of SFFs selected in each state will now vary somewhat with the total number of nursing homes in the state. The national total number of facilities will increase by about 30%.
2.	**Selection Criteria:** One year's data on nursing home performance has been used in the past. States reported that the list of poorly performing nursing homes generated from one's year's worth of data did not match well with their knowledge of which nursing homes had the worst performance.	Three year's of data on each nursing home's performance will now be used. States will pick from an expanded list. Facilities that significantly improve may be removed from the list so the state may move on to other facilities on the candidate list.
3.	**Enforcement**: Many facilities have remained on the SFF list for some time without improving.	More robust enforcement will include: (a) Required sanctions if significant progress does not occur; (b) 18 months & 3 surveys without significant improvement will precipitate a notice of termination from Medicare/ Medicaid.
4.	**Reporting**: It has been time-consuming for states to prepare the necessary reports for transmittal to CMS.	Improvements to the ASPEN information system will enable CMS to extract the necessary information. States will no longer need to send the reports.

How the Special Focus Facility Program Will Be Changed

Number of Facilities: The attachment to this memo identifies the number of SFFs that must be included in the program. The specified number of facilities will be selected by the state from the larger candidate list provided by CMS. We encourage states to select a larger number when possible. In the past, the minimum number of facilities was "2," regardless of the total number of facilities in the state.

Selection & Ability to Focus on Additional Facilities: We will use three years of data to create the list of potential SFF in each state. States will be provided an expanded list of facilities from which to select. We are also revising the SFF requirements to allow states to remove names of nursing homes that have significantly improved survey results. This will free up resources for states to focus their efforts on nursing homes in need of closer monitoring. Nursing homes that are cited with deficiencies at a scope and severity no higher than "E" on two successive standard surveys without intervening complaint-related deficiencies of "F" or greater may be removed from the SFF program.

More Robust Enforcement for Lack of Significant Progress: Each enforcement authority, i.e., SA or regional office (RO), must impose an immediate sanction on a SFF that fails to achieve and maintain significant progress in correcting deficiencies on the first and each subsequent standard survey after a facility becomes a SFF. Each state must apply its appropriate discretion, in a manner consistent among all affected facilities, in determining significant progress. Decreases in the scope and severity of deficiencies or decreases in the number of deficiencies are both examples of such criteria. Complaint surveys may not be used to determine that a facility's performance has improved. However, the results of a complaint survey may be used as part of the enforcement process. This provision does not prevent the SA or RO from imposing an immediate sanction, even though substantial progress has occurred under this definition, if the sanction fits or is required under CMS policy.

Enforcement sanctions should be of increasing severity. They should include a Civil Money Penalty and/or a Denial of Payment for New Admissions. Each state or CMS should impose these sanctions with 15 days' notice. If, after 18 months and 3 surveys subsequent to being selected as a SFF, a nursing home fails to have made significant progress, a notice of termination from participation in Medicare and Medicaid will be issued. CMS will consider a facility's status and progress as a SFF in setting a reasonable assurance period before a home can reapply to participate in Medicare.

Reduced Reporting Requirements: SAs and ROs will no longer be required to submit a monthly status report on each SFF in their jurisdiction. CMS Central Office will monitor the program by evaluating data collected in ASPEN and submitted to the Central Office database. However, we ask that you still submit any changes to your list of SFFs that are selected from the candidate list that we supply.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

State	# Nrsg Homes	# Special Focus Facilities
Guam	1	0
Virgin Islands	1	0
Puerto Rico	6	0
Alaska	14	0
4 states/territories		
District Of Columbia	21	1
Wyoming	39	1
Delaware	42	1
Vermont	42	1
Nevada	43	1
Hawaii	45	1
Idaho	80	1
New Hampshire	81	1
New Mexico	82	1
North Dakota	83	1
Utah	92	1
Rhode Island	95	1
12 states	12facilities	
Montana	101	2
South Dakota	113	2
Maine	118	2
Arizona	134	2
West Virginia	138	2
Oregon	139	2
South Carolina	178	2
Mississippi	209	2
Colorado	216	2
Alabama	229	2
Nebraska	235	2
Maryland	240	2
Arkansas	245	2
Connecticut	248	2
14 states	28 facilities	
Washington	256	3
Virginia	287	3
Kentucky	296	3
Louisiana	318	3

State	# Nrsg Homes	# Special Focus Facilities
Tennessee	341	3
New Jersey	360	3
Georgia	365	3
Kansas	377	3
Oklahoma	378	3
9 states	27 facilities	
Wisconsin	410	4
Minnesota	421	4
North Carolina	422	4
Michigan	432	4
Massachusetts	481	4
Iowa	490	4
Indiana	526	4
Missouri	550	4
8 states	32 facilities	
New York	669	5
Florida	696	5
Pennsylvania	732	5
Illinois	834	5
Ohio	998	5
Texas	1,172	5
6 states	30 facilities	
California	1,321	6
56 states/territories	Total 135 facilities	

Insert 9

Centers for Medicare and Medicaid Services
Survey & Certification Letter
S&C-05-14
Electronic Signature Guidance

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-05-14

DATE: **January 13, 2005**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Electronic Signature Guidance - Clarification

This memorandum replaces S&C-04-46 dated September 9, 2004 that provided guidance to Regional Office (RO) and State Agency (SA) personnel regarding the use of electronic signatures.

The intent of this clarification is to inform certified long-term care providers who have the capability to implement electronic signatures for their MDS documentation that they may do so whether or not the clinical record is entirely electronic.

Background

The Centers for Medicare & Medicaid Services (CMS) has received requests for authorization to use electronic signatures on the MDS and the clinical record. Demand for the use of electronic signatures and current CMS requirements to retain hard copies of the MDS and clinical record has raised operational issues and concerns by both facility staff and authorized reviewers.

CMS has adopted the current hospital guidelines for electronic medical records and electronic signatures for other providers that do not have specific regulations governing the use of electronic signatures, such as Rural Health Clinics and Federally Qualified Health Centers. In addition, some states have specific requirements for the use of electronic signatures. A few states do not address electronic signatures in their statutes or regulations, but may permit the use of electronic signatures with approval from fiscal intermediaries or state authorities.

Discussion

Based on a review of the State Operations Manual (SOM), conflicting messages exist in current CMS policy. Some of our existing guidance requires the need for a hard copy of all MDS forms whether or not the facility is able to document signatures electronically, while another reference in the guidance allows the use of electronic signatures rather than a hard copy. Specifically:

- Appendix PP (Guidance to Surveyors – Long-Term Care Facilities) guidance regarding 42 CFR 483.20 (d) states, "Whether or not the facility's clinical record system is entirely electronic, a hard copy of all MDS forms, including the signatures of the facility staff attesting to the accuracy and completion of the records must be maintained in the resident's clinical record."

- Appendix PP guidance regarding 42 CFR 483.20(i) states, "Whether the MDS forms are manually completed or computer-generated following data entry, each individual assessor is responsible for certifying the accuracy of responses on the forms relative to the resident's condition and discharge status. Manually completed forms are signed and dated by each individual assessor the day they complete their portion(s) of the MDS record. When MDS forms are completed directly on the facility's computer (e.g., no paper form has been manually completed), then each individual assessor signs and dates a computer generated hard copy, after they review it for accuracy of the portion(s) they completed. Back dating completion dates is not acceptable."

- Appendix R, (Revised Long-Term Care Resident Assessment Instrument User's Manual, version 2.0, December 2002) with updates through June 2004 states, "Until such time as CMS adopts an electronic signature standard that is compatible with pending HIPAA requirements for electronic signature, all facilities are required to sign and retain hard copies of the MDS." Another policy found in the RAI Manual states, "There is no requirement to maintain two copies of the form in the resident's record (the hand written and computer-generated MDS). Either a hand written or a computer-generated form is equally acceptable."

- However, Appendix PP guidance regarding 42 CFR 483.75(l)(1) states, "In cases in which facilities have created the option for an individual's record to be maintained by computer, rather than a hard copy, electronic signatures are acceptable." Further guidance provides an example of how the facility may set up a system with safeguards to prevent unauthorized access to an individual's record maintained by computer.

Decision
Nursing homes may use electronic signatures on the MDS when permitted to do so by state and local law and when this is authorized by the long-term care facility's policy. Facilities must have written policies in place to ensure that they have proper security measures to protect use of an electronic signature by anyone other than to which the electronic signature belongs. The policy must also ensure that access to a hard copy of clinical records is made available to surveyors and others who are authorized access to clinical records by law.

Long-term care facilities that are not capable of maintaining the MDS signatures electronically must adhere to the current requirements addressing the need for either a hand-written copy or a computer-generated form. All state licensure and state practice regulations continue to apply to certified long-term care facilities. Where state law is more restrictive than federal requirements, the provider needs to apply the state law standard.

For questions regarding this memo, please contact Rosemary Dunn at (410) 786-1372 or e-mail at Rdunn@cms.hhs.gov.

Effective Date: The information contained in this memorandum clarifies current policy and must be implemented no later than 30 days after issuance of this memorandum.

Training: The information contained in this announcement should be shared with all survey and certification staff, their managers, the RO/state training coordinators, and all long-term care providers.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Insert 10

Centers for Medicare and Medicaid Services
Survey & Certification Letter
S&C-05-17
Description of Recent Changes Made to
State Operations Manual (SOM), Appendix PP

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-05-17
DATE:February 10, 2005

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Description of Recent Changes Made to State Operations Manual (SOM), Appendix PP

Background

The Centers for Medicare & Medicaid Services (CMS) has a project underway to convene expert panels to assist in developing revisions to interpretive guidelines at several key Tags in the State Operations Manual (SOM), Appendix PP. This ongoing project has now produced the first of the changes to the SOM. New guidance for Tag F314, Pressure Ulcers (Sores), was issued in Transmittal 4 on 11/12/04. The guidance contains, in addition to interpretive guidelines, an investigative protocol and specific severity guidance for determining the correct level of severity of outcome to residents from deficiencies at F314. As part of the F314 revision, a minor addition was made to interpretive guidelines at F309, Quality of Care, to provide information on non-pressure ulcers. Each Tag revision is expected to follow a similar format.

A second change was made to the SOM, Appendix PP in Transmittal 5, which was issued 11/19/2004. In this Transmittal, the following changes were made:

- We corrected typographical errors;
- We moved certain regulatory text and guidelines that had no Tag numbers, but instead referred to certain Tags, to the Tags where they belong. The language that was moved is considered part of the text of the Tag to which it was moved. For the purpose of determining if a deficiency should be designated as substandard quality of care, survey teams should refer to the Tag and where it is located, even though some language from other regulatory sections may have been added to the Tag;
- We changed certain regulatory language due to 2003 changes to the regulations; and

- We changed Appendix P, the Survey Protocol for Long Term Care Facilities, to remove the investigative protocol for pressure ulcers that was part of Task 5C, Resident Review. This protocol is now replaced with the new investigative protocol at F314 in Appendix PP.

Discussion

CMS plans several more Tag revisions over the next several months. Each Tag is proceeding through expert panel development, public comment, and panel review of comments, with revisions based on those comments, and then internal clearance. For this reason, each Tag is on its own time schedule for issuance as final. We expect changes to the following Tags in FY '05:

- F315 & F316, Incontinence and Catheters (the two tags will be collapsed into one, F315);
- F501, Medical Director;
- F248 & F249, Activities and Activity Director;
- F520 & F521, Quality Assessment and Assurance (the two Tags will be collapsed into one F520); and
- F323 & F324, Accidents and Supervision (the two Tags will be collapsed into one, F323).

In addition, we will be adding new guidance, the Psychosocial Outcome Guide, to Appendix P, at Part V, Deficiency Categorization. This new Guide supplements the general guidance on severity determination at this Part with additional guidance for determining severity based on psychosocial outcomes of any deficiency to residents.

In FY '06, we expect changes to the Tags:

- F329, Unnecessary Drugs;
- The entire Pharmacy section at 483.60;
- F325, Nutrition;
- F371, Safe Food Handling; and
- F309 to provide new guidance on issues of pain and palliative care.

We will be continuing our efforts to select and revise additional Tags, once we have determined which Tags need revision.

For questions on this memorandum, please contact Karen Schoeneman at (410) 786-6855 or via e-mail at kschoeneman@cms.hhs.gov.

Effective Date: The information in this memorandum should be shared with survey staff within 30 days of the publication date.

Training: The information contained in this announcement should be shared with all long term care survey staff, their managers and the state/RO training coordinators.

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Attachment

CMS Manual System

Pub. 100-07 State Operations Provider Certification

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Transmittal 4 **Date: NOVEMBER 12, 2004**

SUBJECT: **Guidance to Surveyors for Long Term Care Facilities**

I. SUMMARY OF CHANGES: Appendix PP, Tag F314, current Guidance to Surveyors, is entirely replaced by this revision which is to be inserted in the Appendix immediately after the regulatory text for F314. To complement the revision of F314, new language is being added to Tag F309 to include certain definitions of non-pressure related ulcers. Hypertext links are added for all Web sites listed in the Overview, (www.ahrq.gov, www.npuap.org, www.amda.org, www.medqic.org, www.wocn.org, and www.healthinaging.org). Hypertext link is added in the Endnotes section to link to a CMS site (www.cms.hhs.gov/medicaid/survey-cert/siqhome.asp) for further information.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: November 12, 2004
IMPLEMENTATION DATE: November 12, 2004

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Appendix PP/483.25/Quality of Care/Tag F309
R	Appendix PP/483.25(c)/Pressure Sores/Tag F314

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
x	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

CMS Manual System

Pub. 100-07 State Operations Provider Certification

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Transmittal 5 **Date: November 19, 2004**

SUBJECT: Revisions to Appendix P (Survey Protocols for Long Term Care Facilities) and Appendix PP (Guidance to Surveyors for Long Term Care Facilities)

I. SUMMARY OF CHANGES: In Appendix P, Task 5C, Resident Review, Part H, Investigative Protocol, Pressure Sore/Ulcer is deleted. The Regulatory and Guidance to Surveyors text that is already part of Appendix PP in areas that are tagged to "refer" to another Tag, have been moved to the proper Tags. Revisions made to Appendix PP (described below) are due to changes in the regulatory language.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: Upon Issuance
IMPLEMENTATION DATE: Upon Issuance

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
D	Appendix P: Task 5C Resident Review, Part H, Investigative Protocol, Pressure Sore/Ulcer is deleted. It has been replaced by a new protocol at Appendix PP, Tag F314.
R	Appendix PP: The following Tags have been changed to move all text that is part of that Tag to be located with the other text of the Tag: F154, F156, F164, F246, F252, F272, F279 F280, F285, F514, and F516. Guidance that was present at some of the sections that were moved that refer the reader to the Tag to which they belong has been removed, since the language is now at the appropriate Tag.
R	Appendix PP: Regulatory language revisions made at F150, F156 -483.10(b)(7)(iv), F386, 483.70(a) – untagged, 483.70(a)(4) – untagged.
R	Appendix PP: Corrections made due to text errors at F333 (Tag was missing), F363 (Tag was missing), F428 (regulatory text missing).

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
x	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Insert 11

Executive Summary of Changes
in 410 IAC 7-24
Food Code

Executive Summary of Changes in 410 IAC 7-24

Section numbers that are related from 410 IAC 7-20 are in parenthesis at the end of each line.

The following are new sections to the food code:

Definitions
Section 2 - Acid foods
Section 3 - Acidified foods
Section 9 - Casing
Section 10 - Catering
Section 16 - Commissary
Section 24 - Disclosure – consumer advisory requirement
Section 32 - Exclude – disease control
Section 55 - Mobile retail food establishment
Section 76 - Reminder – consumer advisory requirement
Section 77 - Restrict – disease control
Section 80 - Risk
Section 89 - Shiga toxin-producing Escherichia coli
Section 101 – Variance

Management and Supervision
Section 113 - Requirements for a mobile retail food establishment
Section 114 - Variance requirements – spells out new ISDH protocol
Section 115 - HACCP plan content requirements

Food
Section 152 - Adopted FDA language
Section 192 - Adopted FDA language

Equipment, Utensil, Linen, Single-Use and Single Service Items
Section 243 - Separated single service and single use from equipment
Section 269 - Requires minimum warewashing requirements
Section 297 - Created a new section for the cleaning frequency of non-food contact equipment (265)
Section 319 - Adopted FDA language on case lot moveability and handling

Water, Plumbing, Water Fixtures and Waste
Section 337 - Requires backsiphonage protection for carbonator devices

The following are amended sections to the food code:

Section 29 - Clarified subsection 7 (23)
Section 39 - Clarified language (31)

Section 46 - Clarified subsection 1 and added subsection 3 (40)
Section 49 - Clarified juice definition (43)
Section 72 - Adopted FDA language (65)
Section 79 - Expanded definition (70)
Section 98 - Expanded definition (87)

Management and Supervision
Section 110 - Plan must now be approved prior to construction (430)
Section 118 - "Demonstration of knowledge" replaces the former foodborne illness prevention training (95)
Section 120 - Added all "shiga toxin producing E. coli and Norovirus" (97)
Section 121 - Added exclusions for "vomiting/diarrhea and Norovirus" (98)
Section 122 - Added exclusions for "vomiting/diarrhea and Norovirus" (99)
Section 128 - Requires hand drying as part of hand washing (106)
Section 129 - Added subsection 10 (107)
Section 131 - Adopted FDA language (109)
Section 133 - Added subsection (c) (110)
Section 134 - Added medical jewelry (111)

Food
Section 153 - Adopted FDA language (183)
Section 161 - Added "HACCP plan" (218)
Section 166 - Changed to 135 degrees (125)
Section 171 - Restricted bare hand contact of ready-to-eat foods to very limited situations (136)
Section 173 - Move the previous subsection (a)(4) to Section 177(a)(5) (138)
Section 182 - Changed to 135 degrees; added additional oven cooking temps/times; Added pooled or hot held in subsection (2)(b)
Game animal cooking temps have also been amended (161)
Section 186 - Changed to 135 degrees (163)
Section 187 - Changed to 135 degrees; stipulated actual date of grandfather termination (173)
Section 188 - Changed to 135 degrees (167)
Section 189 - Changed to 135 degrees; clarified 6 hour cooling period (171)
Section 191 - Adopted FDA language (174)
Section 193 - Written procedure must now be approved before use (175)
Section 195 - Adopted FDA language (176)
Section 196 - Added "disclosure and reminder" requirements (181)

Equipment, Utensil, Linen, Single-Use and Single Service Items
Section 234 - Changed to 135 degrees (146)
Section 242 - Added "cedar planks" (262)
Section 252 - Added the word "or" to make one of the three to be used (290)
Section 281 - Clarified requirements for automatic dispensing of detergents and sanitizers (225)
Section 284 - Added chart (253)
Section 293 - Prohibited warewashing machines from being used to wash food and linens (249)
Section 294 - Added requirement that chemical sanitizer must be present if they are used (257)

Section 295 - Combined the former 264 and 267 into one section (264)
Section 296 - Deleted the non-food contact equipment from this section (265)
Section 303 - Combined the former 275 and 276 into one new section (275)

Water, Plumbing, Water Fixtures and Waste
Section 331 - Clarified (a)(3)(A) and added (a)(3)(D) (299)
Section 335 - Deleted the word “backflow” (305)
Section 336 - Changed “backflow” to “backsiphonage” (310)
Section 338 - Changed “backflow” to “backsiphonage” (312)
Section 342 - Requires hand sinks to have water of at least 100 degrees (303)
Section 355 - Requires service sinks to have water of at least 100 degrees (309)
Section 369 - Changed “backflow” to “backsiphonage” (330)
Section 375 - Prohibits the use of a sewage holding tank except for temporary and mobile retail food establishments (337)

References
Section 452 - Added new references (433)